TABLE *Results of treatment*

Treatment	*No (%) cured*		*No (%) treatment failures*	*No (%) developing PGU**
	Day 3	*Day 10*		
Amoxycillin 3 g + probenecid 1 g:				
Men (n = 43)	42 (97·7)	42	1	6 (14·3)
Women (n = 42)	41 (97·6)	41	1	
Total (n = 85)	83 (97·6)	83	2 (2·4)	
Procaine penicillin 2·4 MU + probenecid 1 g				
Men (n = 51)	49 (96·1)	49	2	10 (20·4)
Women (n = 87)	35 (97·2)	35	1	
Total (n = 87)	84 (96·6)	84	3 (3·4)	

PGU = post-gonococcal urethritis

failure was due to vomiting half an hour after taking oral amoxycillin. All failures were either urethral or urethral and cervical infections. All five oropharyngeal and six rectal infections responded to treatment. Apart from injection pain, there were no adverse reactions to procaine penicillin. Of the two who vomited half an hour and an hour after receiving oral amoxycillin, the former proved to be a treatment failure. Three other patients reported dizziness, loose bowel motions, and a feeling of abdominal fullness with loss of appetite and distaste for smoking.

This study shows that 3 g amoxycillin orally and 2·4 MU procaine penicillin are equally effective in treating uncomplicated gonorrhoea in either sex. Amoxycillin is well tolerated and has few minor side effects.[2 5] Pharyngeal gonorrhoea is known to be difficult to eradicate with single dose oral treatment.[5] Drug regimens have varied, however, and Felman successfully treated all of four cases of pharyngeal gonorrhoea with 3 g oral amoxycillin plus 1 g probenecid.[6] Two of the five cases cured in this study had received the same treatment, the other three had been treated with procaine penicillin. A prospective study of a larger number of patients with oropharyngeal gonorrhoea treated with adequate doses of amoxycillin and probenecid is needed to assess the efficacy of amoxycillin in this condition.

Although post-gonococcal urethritis (PGU) developed in more patients treated with procaine penicillin than with amoxycillin, the difference was not significant ($p = 0·05$). The wide range in the reported incidence of PGU probably reflects differing diagnostic criteria and the diligence with which it is sought.[7]

Amoxycillin is a pleasant tasting suspension, is easily and rapidly absorbed, and has few minor side effects. It therefore seems to be a suitable alternative to injectable preparations and may be recommended for children, those who cannot swallow tablets or capsules, and those who dread injections. Even on the most favourable terms, however, a 3 g sachet still costs five times 2·4 MU procaine penicillin or a comparable dose of ampicillin.

Yours faithfully,

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TO THE EDITOR, *British Journal of Venereal Diseases*

Imported PPNG endemic in London

Sir,

Thin *et al* (*Br J Vener Dis* 1983;**59**;364-80.) provide us with a thorough breakdown of the numerical and demographic details of the above development. As far as it goes, the article is sound, but it is so simplistic and sad. Simplistic and sad because it treats the dynamics of the development superficially and with resignation. At all levels there is lack of integration of the concepts of epidemiological awareness and appropriate control endeavours.

For example, we learn nothing of any discussions leading to agreement that London was the country's most likely target area for the main PPNG invasion in the mid-1970s. There is no evidence that any effort was made to establish a comprehensive control programme to meet such a situation, such as bacteriological monitoring and reporting, special educational activities, or a strengthening of contact tracing services. That no special efforts were made even after the invasion was under way is suggested in the revelation that follow up "principles" apparently remained unaltered from those embraced nearly 20 years ago.

Such remarks as "Casual partners and prostitutes ..... are notoriously difficult to trace" and "While the proportion of PPNG strains is still relatively low, the rate of increase is alarming" seem more likely to engender continuing ennui rather than action.

Saddest of all perhaps, is that there is no discussion as to why Liverpool succeeded in containing its outbreak and London so conspicuously failed. It is perhaps excusable that London failed to control the invasion. What is surely inexcusable is that those concerned failed to try. Even now there is no evidence or promise that we in the provinces can hope for more enlightened neighbours.

The article of Thin *et al* does have positive and hopeful aspects. It serves to remind all STD workers in the United Kingdom that some 40% of the country's STD infection occurs in London. It should be clear to workers in the centres of excellence of the metropolis that competition between them is not enough. They have on occasion an obligation to seek concensus and act cooperatively in the national interest. Secondly, and more important, there is now a third, potentially effective, option in the debate as to whether we do or do not want audit—we can publish and find ourselves damned.

Yours faithfully,

R S Morton
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